IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

RUTH P. SCOTT	:	CIVIL ACTION
v.	:	
HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY	:	NO. 03-3696

MEMORANDUM

Dalzell, J. May 13, 2004

In this action brought under the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001 et seq., plaintiff Ruth Scott seeks an award of long-term disability benefits under an insurance policy that defendant Hartford Life and Accident Insurance Company issued to her former employer, Cellco Partnership, d/b/a Bell Atlantic Mobile ("Bell Atlantic").

The parties have filed cross-motions for summary judgment. For the reasons provided below, we deny both motions and remand this matter to Hartford for further consideration of Scott's application for benefits.

Factual Background

A. The Policy

Hartford's Group Long Term Disability Insurance Policy ("the Policy") defines disability as the insured's inability to perform one or more essential occupational duties as a result of accidental bodily injury, sickness, mental illness, substance abuse, or pregnancy. Policy at 6 (R. at H31). It grants Hartford full discretion and authority in determining eligibility for benefits and in construing and interpreting the terms of the

Policy. Id. at 24 (R. at H49). Moreover, the Policy requires a claimant to submit proof of loss, including

> any and all medical information, including x-ray films and photocopies of medical records, including histories, physical, mental or diagnostic examinations, and treatment notes,

and it provides that "[a]ll proof submitted must be satisfactory to us." Id. at 24-25 (R. at H49-H50). Finally, in a provision that has been quite consequential in this case, the Policy imposes a two-year limit on benefits for disability arising from mental illness, which it defines as "any psychological, behavioral or emotional disorder or ailment of the mind, including physical manifestations" of such disorders. Id. at 18 (R. at H43).

B. Scott's Claim

Scott worked for Bell Atlantic as a door-to-door salesperson from early 1997 through February of 1999, when she stopped as a result of her severe depression. Pursuant to the mental illness terms of the Policy, Scott qualified for and received benefits for a twenty-four month period that expired August 10, 2001.

After her benefits ended, Scott notified Hartford's claim examiner, Laurence Contello, that she was suffering from lupus, ocular migraines, osteoarthritis, and ulcerative colitis, and she requested resumption of benefits under the Policy's physical disability provisions. Letter from Scott to Contello of 12/3/01 (R. at H144). On January 18, 2002, Contello invited

Scott to "submit documentation from an attending physician relating to the physical diagnoses which you listed." Letter from Contello to Scott of 1/18/02 (R. at H138). Scott duly submitted a letter from her primary care physician, Dr. Christine Dacier, which detailed her physical conditions as follows:

> She has ulcerative colitis, for which she is being treated by Dr. Timothy Orphanides (gastroenterologist). She is being seen by Dr. Damon L. Bass (rheumatologist) regarding her osteoarthritis, fibromyalgia, and possible lupus. He is also investigating the possibility that she may have a spondyloarthropathy related to her ulcerative colitis. Her dermatologist, Dr. Fairfield, did a biopsy of a skin lesion, the pathology of which was consistent with lupus. She has seen an opthalmologist regarding her ocular migraines, which she has daily. The ocular migraines interfere with her vision (in particular, causing severe blurry vision) and can last for several hours. She has daily back pain which prevents her from being able to sit or stand for long periods. She has difficulty getting out of a chair. She has pain in her hands and knees daily. Her severe joint pains and ocular migraine symptoms would interfere with her ability to perform the duties of a job.

Letter from Dacier to Contello of 3/14/2002 (R. at H127).

In support of her letter, Dr. Dacier provided Contello with reports from Drs. Bass and Fairfield, a report on Scott's osteoarthritis from Dr. Donald E. Parlee of the Department of Diagnostic Imaging at Doylestown Hospital, and her own notes on Scott from June 20, 2001 to March 7, 2002. See R. at H128-H137.

On April 23, 2002, Contello rejected Scott's request for benefits. In his three-page letter, Contello summarized the contents of Dr. Dacier's submission in great detail but then concluded that

> [t]he above medical information received does not provide sufficient medical information to support your

> disability for a physical condition(s). The information Dr. Dacier submitted did not have any office notes or test results to support her findings along with your other physician's [sic] findings of the physical conditions that you have been diagnosed with, which render you disabled.

Letter from Contello to Scott of 4/23/02 (R. at H125-H126).

Scott responded by arranging for her rheumatologist, Dr. Bass, to write a new letter to Contello. Dr. Bass opined that Scott's fibromyalgia and osteoarthritis, "coupled with her depression, which is most likely aggravated by her fibromyalgia and osteoarthritis, make it exceedingly difficult for her to pursue and/or keep any gainful employment." Letter from Bass to Contello of 8/28/02 (R. at H120). Dr. Bass also provided Contello with a copy of a letter he had sent Dr. Dacier on July 23, 2002 that summarized Scott's case history and reported his most recent findings and recommendations. In support of his diagnosis of fibromyalgia, Dr. Bass reported that he had palpated Scott and elicited pain from a number of tender point sites. See Letter of Bass to Dacier of 7/23/02 (R. at H121-H122).

Five months later, Hartford again denied Scott's request for benefits. As before, Contello's letter summarized Dr. Bass's submission but cursorily concluded that the rheumatologist had not supported his findings with "test results." Letter from Contello to Scott of 1/30/03 (R. at H111).

Discussion

A. Hartford's Motion for Summary Judgment

1. Exhaustion

A claimant challenging the denial of benefits under an ERISA plan must first exhaust the plan's internal administrative remedies before seeking judicial relief. Majka v. Prudential Ins. Co. of N. Am., 171 F.Supp.2d 410, 414 (D.N.J. 2001). Hartford argues that Scott never formally appealed the claim denial of April 23, 2002 and has suggested that we stay this action so that it can reconsider her claim.

Hartford's assertion that Scott failed to exhaust her administrative remedies is without merit. Contello's letter of April 23 notified Scott that if she wished to appeal Hartford's decision, she or her authorized representative should submit an "appeal letter" along with any other records or information related to her claim. R. at H126. Scott complied with Contello's instructions by arranging for her rheumatologist, Dr. Bass, to send a letter, and she personally wrote to Contello on November 12, 2002 and January 13, 2003. See R. at 114 & 116. Contello clearly regarded these communications as an appeal because his letter of January 30, 2003 concluded that Dr. Bass's submission was "insufficient to reverse our decision." R. at H111. On this record, we conclude that Scott has exhausted her administrative remedies.

2. Pinto Analysis

Under ERISA, a plan administrator or fiduciary's denial of benefits is generally subject to de novo review unless the plan grants the administrator discretion to determine claimants' eligibility for benefits. Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 102, 111-12 (1989). In such cases, the decision is subject to "arbitrary and capricious" review, pursuant to which a court may overturn the denial of benefits only if it is "without reason, unsupported by substantial evidence or erroneous as a matter of law." Abnathya v. Hoffmann-La Roche, Inc., 2 F.3d 40, 45 (3d Cir. 1993).

Our Court of Appeals added another dimension when it later held that "when an insurance company both funds and administers benefits, it is generally acting under a conflict that warrants a heightened form of the arbitrary and capricious standard of review." Pinto v. Reliance Standard Life Ins. Co., 214 F.3d 377, 378 (3d Cir. 2000). In applying Pinto, the court must calibrate the level of review to neutralize the conflict of interest, whose severity the court must determine in light of such factors as the sophistication of the parties, the information accessible to the parties, the financial arrangement between the insurer and the company, and the financial and structural health of the company. Id. at 391-92. The decisionmaker's inconsistent treatment of facts, selective use of evidence, and other "suspicious events" can also suggest the likelihood of self-dealing and require the court to increase the

stringency of its review. Id. at 393-94; see also Weinberger v. Reliance Standard Life Ins. Co., 54 Fed. Appx. 553, 557 (3d Cir. 2002) (concluding that "moderate scrutiny" was unduly deferential because insurance company had rejected uncontradicted evidence from treating physician, and remanding case to district court for application of a more heightened standard of review).[1]

Hartford acknowledges that some version of heightened review is appropriate here because it both funds and administers the plan, but it contends that, in the absence of other Pinto factors, a "heightened but very close to arbitrary and capricious" standard of review is appropriate here. Scott seeks a more stringent standard of review in view of Hartford's cryptic and cursory rejection of all her medical evidence. Pl.'s Resp. (Def.'s Mot. S.J.) at 5; see also Weinberger, 54 Fed. Appx. at 557 (total rejection of uncontradicted medical evidence was not "consistent with an exercise of discretion by a fiduciary acting free of the interests that conflict with those of the beneficiaries").

We agree with Scott that Hartford's Bartleby-like treatment of her claim is sufficiently suggestive of self-dealing to warrant heightened arbitrary and capricious review. Under

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1. We note that Weinberger highlights the oddly circular nature of Pinto analysis, which invites the court to fix the standard of review by reference to aspects of the insurer's decisionmaking process that are then likely to factor into the court's disposition of the case itself. Judge Sloviter, perhaps more diplomatically, has recently referred to Pinto's language as "enigmatic." Stratton v. E.I. DuPont de Nemours & Co., 363 F.3d 250, 255 (3d Cir. 2004)

this standard, we will not substitute our own judgment for Hartford's, and we will overturn the insurer's decision "only if it is clearly not supported by the evidence in the record or the administrator has failed to comply with the procedures required by the plan." Stratton, 363 F.3d at 256.[2]

3. Application of Heightened Arbitrary and Capricious Review

Hartford's motion for summary judgment argues that its decision to deny benefits was reasonable and justified because the medical evidence does not suggest that Scott is totally disabled and because she has not come forward with objective test results to corroborate her physicians' diagnoses. Moreover, for the first time since Scott sought the resumption of benefits on the basis of physical disability, Hartford advances the position that "her current problems stem from her mental illness." Def.'s Mem. at 14.

We acknowledge that the severity and etiology of Scott's physical condition are unclear on the record before us. See infra at 11-12 (denying plaintiff's motion for summary judgment). Nevertheless, we conclude that Hartford's denial of benefits was arbitrary and capricious because its communications with Scott during the claims process were so opaque that they violated ERISA's most basic notice requirements.

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2. In any event, it is highly unlikely that application of the standard of review that Hartford has advocated, which our Court of Appeals has called "slightly heightened" review in its latest foray into the hermeneutics of Pinto, would alter the outcome of this case. See Stratton, 363 F.3d at 255.

ERISA requires that a plan must "provide adequate notice in writing to any participant . . . whose claim for benefits . . . has been denied, setting forth the specific reasons for such denial, written in a manner calculated to be understood by the participant." 29 U.S.C. § 1133(1). Moreover, the plan must offer "a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review . . . ." § 1133(2). The Department of Labor regulations implementing § 1133 require the notice of denial to provide the claimant with, inter alia, the "specific reason or reasons for the adverse determination" and "[a] description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary." 29 C.F.R. § 2560.503-1(g)(i) & (iii). Violation of ERISA and its implementing regulations constitutes "a significant error on a question of law" and may so taint the denial of benefits that it warrants a finding that the plan administrator's decision was arbitrary and capricious. Cook v. New York Times Co. Long-Term Disability Plan, 2004 WL 203111, at *5 (S.D.N.Y. Jan. 30, 2004).

Contello's letters of April 23, 2002 and January 30, 2003 did not satisfy ERISA's notice requirements. As we have already noted, the April 23rd letter stated in the most general terms that "[t]he information Dr. Dacier submitted did not have any office notes or test results to support her findings along with your other physician's findings of the physical conditions

that you have been diagnosed with . . . ." R. at H125-126. Not only is this statement ambiguous -- is Contello complaining about the lack of substantiation from all of Scott's specialists, or only Dr. Dacier? -- but it completely fails to explain why the specialists' notes and reports were inadequate and what testing would be necessary to satisfy Hartford. Indeed, Hartford's only attempt to spell out its evidentiary standard has been in the memorandum supporting its motion for summary judgment, which notes that "[t]here are no EEGs regarding her migraine symptoms, there is no blood work or other objective testings which may have confirmed the diagnosis of Lupus." Def.'s Mem. at 16.

The letter of January 30th, which denies Scott's appeal for lack of "test results," similarly neglects to describe what evidence would have been necessary to establish disability. Moreover, the letter glaringly failed to explain Hartford's rejection of Dr. Bass's conclusion that Scott suffers from fibromyalgia. As many ERISA decisions have noted in recent years, there is no objective laboratory test for fibromyalgia at present. See, e.g., Mitchell v. Prudential Health Care Plan, 2002 WL 1284947, at *10 n.6 (D. Del. June 10, 2002); Dorsey v. Provident Life & Acc. Ins. Co., 167 F.Supp.2d 846, 855 (E.D. Pa. 2001).

In the absence of a laboratory test, physicians diagnose fibromyalgia through use of the "pressure point" or "tender point" test. See Sanderson v. Continental Cas. Corp., 279 F.Supp.2d 466, 476 (D. Del. 2003); McCardle v. UNUM Life Ins.

Co. of Am., 2001 WL 1149364, at *3 (D. Minn. Sept. 26, 2001); Russell v. UNUM Life Ins. Co. of Am., 40 F.Supp.2d 747, 750-51 (D.S.C. 1999). Dr. Bass performed this test on July 23, 2002 and elicited pain from some nine "tender point sites." See Bass Report of 7/23/02, at 2 (R. at H122). Contello neglected even to acknowledge that Dr. Bass had used this widely accepted procedure, let alone explain why the result of this test was insufficient to sustain his diagnosis of fibromyalgia.

In pointing out the deficiencies of Hartford's two decisions in this case, we do not imply that the insurer was obliged to provide Scott with a learned treatise on medical diagnostics, conduct an independent medical examination, sacrifice its contractual right to interpret the Policy, or give special deference to the views of her treating physicians. Instead, ERISA required Hartford to engage in what the Ninth Circuit has described as a "meaningful dialogue" with Scott in which it explained its decision and clarified what information would be necessary to bolster her application. Booton v. Lockheed Med. Benefit Plan, 110 F.3d 1461, 1463 (9th Cir. 1997). Having failed to do so, and having only said, in essence, "I prefer not to," its decision was arbitrary and capricious. Accord Sanderson, 279 F.Supp.2d at 474-75.

B. Scott's Motion for Summary Judgment

Scott's motion for summary judgment seeks an award of benefits on the ground that she has sufficiently established her right to benefits. Courts occasionally grant outright awards of

benefits in ERISA cases where the administrative record is complete, the denial of benefits was arbitrary and capricious, and there is no genuine issue of material fact as to whether the plaintiff is disabled within the meaning of the plan. See, e.g., Levinson v. Reliance Standard Life Ins. Co., 245 F.3d 1321, 1327-28 (11th Cir. 2001); Cohen v. Standard Ins. Co., 155 F.Supp.2d 346, 354-55 (E.D. Pa. 2001).

In this case, summary judgment in Scott's favor would be inappropriate. Although Hartford's denial of benefits was arbitrary and capricious for failure to satisfy ERISA's notice requirements, the administrative record is incomplete and at this time does not conclusively show that she is entitled to prevail on her claim. As we have already noted, Dr. Bass reported to Hartford that Scott's fibromyalgia and osteoarthritis are intertwined with her depression, which raises the question of whether her physical ailments alone would qualify her as disabled within the meaning of the Plan. Moreover, apart from her physicians' assertions that Scott is disabled, the record sheds little light on the overall severity of her physical condition.

C. Remand

Having denied both parties' motions for summary judgment, we will remand this action to Hartford so that Scott can have a full and fair opportunity to present her claim for benefits. On remand, Hartford should review the record, along with any other records or information that Scott can provide at this time. If Hartford again concludes that Scott is not

entitled to benefits, it should explain its rationale, provide her with a final opportunity to appeal, and outline the forms of evidence that Scott must present on appeal to prove disability due to fibromyalgia, osteoarthritis, lupus, and her other conditions.

Finally, we note that we are troubled by Hartford's belated (and possibly litigation-induced) assertion that Scott's physical conditions actually arise from her depression and are thus subject to the two-year limitation on benefits for mental illness.[3] If Hartford plans to take this position when it reconsiders Scott's claim, it should confirm and meaningfully explain its intention at the outset so that Scott, her counsel, and her physicians can craft a meaningful response.

Conclusion

We therefore deny Hartford's motion for summary judgment because its denial of benefits was arbitrary and capricious. We deny Scott's motion for summary judgment because there remain many questions of material fact as to whether she is disabled within the meaning of the plan, and we remand Scott's claim to Hartford for further proceedings consistent with this opinion.

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3. If the facts of this case had been closer, we would have been obliged in our Pinto analysis to consider the interesting question of whether an insurer's decision in the course of litigation to offer a new justification for its denial of a claim should trigger heightened review. See Pinto, 214 F.3d at 393-94 (noting that inconsistent treatment of facts during claim process is a procedural anomaly warranting heightened review).

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v.	:	
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HARTFORD LIFE & ACCIDENT	:	
INSURANCE CO.	:	NO. 03-3696

ORDER

AND NOW, this 13th day of May, 2004, upon consideration of plaintiff Ruth Scott's motion for summary judgment (docket entry # 10) and defendant Hartford Life and Accident Insurance Company's response thereto, Hartford's motion for summary judgment (docket entry # 11) and Scott's response thereto, and in accordance with the accompanying Memorandum, it is hereby ORDERED that:

1. The parties' motions for summary judgment are DENIED;

2. Scott's claim for benefits is REMANDED to Hartford for further proceedings consistent with the Memorandum;

3. The Clerk of Court shall TRANSFER this action to the Court's civil suspense docket; and

4. Scott shall REPORT every ninety days on the status of the remand proceedings.

BY THE COURT:

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Stewart Dalzell, J.